Print Form

INJURED EMPLOYEE'S INCIDENT REPORT FORM

Print Employee's Name_____ Today's Date_____

SS#_____ Phone where you can be reached_____

Employer_____ Supervisor_____
(manager, head custodian ,principal, etc.,)

INCIDENT INFORMATION

Date of Injury_____ Time_____am/pm Date Reported_____

To Whom Reported?_____ Did you miss time from work for the injury? Yes/No

If yes, give dates and times_____

Returned to work? Yes/No Full Duty / Light Duty ***If No***, date expect to return_____

What part of your body was injured? (*i.e. right leg, left arm)*_____

What is the nature of your injury? *(i.e. cut, sprain, bruise)*_____

Explain in detail how the injury occurred? _____

_____

_____

Where did the injury occur? *(physical location)*_____

Any witnesses? Yes / No ***If yes***, give names_____

Did you seek medical treatment? Yes / No ***If yes***, give date and time_____

Physician's name_____ Return visit date_____

What type of treatment are you receiving? _____

How are you getting along now? _____

Have you injured this part of your body before? Yes / No ***If yes,*** explain when, how and to what extent:_____

How would you prevent a similar accident?_____

_____

Signature of Employee_____ Date_____